


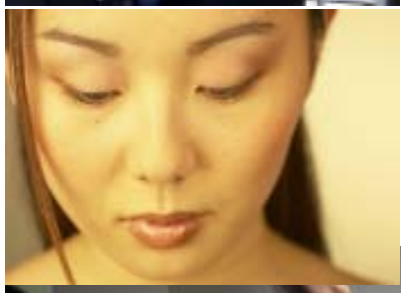


Utah Injury Prevention Strategic Plan 2006

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Acknowledgements

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Introduction

In Utah, injury is a significant public health problem and a leading cause of death and disability. It is the leading cause of death for people age 1 – 44 years and the leading cause of years of potential life lost. Each year injuries account for over 1,000 deaths, nearly 10,000 hospitalizations, and over 193,000 emergency department visits among the 2.5 million residents of Utah.[1] These numbers do not take into account the injuries treated in clinics, doctor's offices, schools, work sites and homes. Most injuries do not directly result in death, but often are associated with disability, loss of productivity, costs to the health care system, and strains on community and family support systems, in addition to the direct pain and/or grief experienced.

The financial costs of injury at the national level are more than $224 billion (including direct medical care, rehabilitation, lost wages, and lost productivity) each year. The federal government pays out $12.6 billion for injury-related medical costs and $18.4 billion for death and disability benefits. Insurance companies and other private resources expend more than $161 billion.[2] It is difficult to determine the full economic impact of injury in Utah (medical costs, lost wages, disability, etc.). However, hospital and emergency department charges added up to over $249 million in Utah for the treatment of injuries in 2003.[1]

Injury is consistently one of the top 10 causes of death for all age groups in the nation and in Utah. The page 3 tables illustrate the 10 leading causes of death for Utah with injury highlighted and the 10 leading causes of injury deaths for Utah.[3] Note the high rates of injury and death for younger age groups.

Unintentional Injury Addressed in the Utah Plan

In the Utah Injury Prevention Strategic Plan, seven primary areas of focus are addressed: Three are specific to unintentional injury and four are specific to intentional injury.

Unintentional injuries are inflicted without specific willful intent to cause harm, whether to oneself or others. The areas specific to unintentional injury addressed in the Utah plan are:

- Pedestrian and Bicycle Safety
- Motor Vehicle Seatbelt Use
- Child Restraint Safety

Intentional Injury Addressed in the Utah Plan

Intentional injury within public health often refers to willful violence, whether doing harm to oneself and/or harm to another. The areas specific to intentional injury addressed in the Utah plan are:

- Sexual Violence
- Intimate Partner Violence
- Suicide
- Child Maltreatment

There are numerous additional types of injury not addressed in this plan, such as injuries and deaths from falls, fires, poisonings, drownings, firearms, and at workplaces. This plan is intended as a framework for a comprehensive state injury prevention plan and could include additional injury focus areas in the future.

Organization of the Utah Injury Prevention Strategic Plan

The plan is divided into seven primary injury focus areas. Each focus area includes background information, current data, and action items.

10 Leading Causes of Death for Utah, 1999 – 2003

	Age Groups											
Rank	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 368	Unintentional Injury 106	Unintentional Injury 65	Unintentional Injury 71	Unintentional Injury 306	Unintentional Injury 321	Unintentional Injury 400	Malignant Neoplasms 421	Malignant Neoplasms 1,069	Malignant Neoplasms 1,924	Heart Disease 12,301	Heart Disease 14,586
2	Short Gestation 152	Congenital Anomalies 38	Malignant Neoplasms 24	Suicide 19	Suicide 135	Suicide 181	Suicide 307	Unintentional Injury 413	Heart Disease 675	Heart Disease 1,171	Malignant Neoplasms 8,159	Malignant Neoplasms 11,885
3	SIDS 69	Malignant Neoplasms 22	Congenital Anomalies 7	Malignant Neoplasms 14	Malignant Neoplasms 34	Malignant Neoplasms 49	Malignant Neoplasms 160	Suicide 369	Unintentional Injury 363	Diabetes Mellitus 312	Cerebro-vascular 4,079	Cerebro-vascular 4,493
4	Maternal Pregnancy Comp. 63	Homicide 18	Benign Neoplasms 5	Congenital Anomalies 10	Heart Disease 19	Homicide 44	Heart Disease 88	Heart Disease 273	Suicide 269	Chronic Low. Respiratory Disease 298	Chronic Low. Respiratory Disease 2,368	Unintentional Injury 3,374
5	Placenta Cord Membranes 51	Influenza & Pneumonia 7	Influenza & Pneumonia 5	Heart Disease 4	Homicide 19	Heart Disease 18	Homicide 67	Diabetes Mellitus 82	Liver Disease 160	Unintentional Injury 277	Diabetes Mellitus 1,966	Chronic Low. Respiratory Disease 2,780
6	Unintentional Injury 39	Perinatal Period 7	Heart Disease 3	Influenza & Pneumonia 4	Congenital Anomalies 18	Congenital Anomalies 17	Diabetes Mellitus 34	Liver Disease 75	Diabetes Mellitus 136	Cerebro-vascular 219	Influenza & Pneumonia 1,853	Diabetes Mellitus 2,545
7	Circulatory System Disease 38	Septicemia 7	Homicide 3	Homicide 3	Diabetes Mellitus 5	Diabetes Mellitus 7	Congenital Anomalies 20	Homicide 50	Cerebro-vascular 124	Liver Disease 141	Alzheimer's Disease 1,507	Influenza & Pneumonia 2,067
8	Neonatal Hemorrhage 33	Heart Disease 5	Suicide 3	Anemias 2	Influenza & Pneumonia 5	Cerebro-vascular 6	Influenza & Pneumonia 18	HIV 46	Chronic Low. Respiratory Disease 85	Suicide 115	Unintentional Injury 1,012	Suicide 1,577
9	Intrauterine Hypoxia 27	Benign Neoplasms 3	Six Tied 1	Diabetes Mellitus 2	Cerebro-vascular 3	Complicated Pregnancy 6	Cerebro-vascular 12	Cerebro-vascular 41	Viral Hepatitis 55	Influenza & Pneumonia 70	Nephritis 752	Alzheimer's Disease 1,536
10	Bacterial Sepsis 23	Cerebro-vascular 2	Six Tied 1	Six Tied 1	Two Tied 2	Septicemia 6	Benign Neoplasms 11	Influenza & Pneumonia 41	Influenza & Pneumonia 53	Two Tied 47	Parkinson's Disease 690	Nephritis 874

Data Source: National Center for Health Statistics, National Vital Statistics System

10 Leading Causes of Injury Deaths, Utah, 1999 - 2003

	Age Groups											
Rank	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Unintentional Suffocation 24	Unintentional MV Traffic 35	Unintentional MV Traffic 41	Unintentional MV Traffic 44	Unintentional MV Traffic 233	Unintentional MV Traffic 221	Unintentional MV Traffic 229	Undetermined Poisoning 298	Undetermined Poisoning 204	Unintentional MV Traffic 147	Unintentional Fall 332	Unintentional MV Traffic 1,570
2	Unintentional MV Traffic 8	Unintentional Drowning 25	Unintentional Drowning 7	Suicide Suffocation 9	Suicide Firearm 75	Suicide Firearm 98	Undetermined Poisoning 208	Unintentional MV Traffic 207	Unintentional MV Traffic 170	Suicide Firearm 76	Unintentional MV Traffic 234	Suicide Firearm 864
3	Homicide Unspecified 7	Unintentional Pedestrian, Other 14	Suicide Suffocation 3	Suicide Firearm 8	Suicide Suffocation 42	Undetermined Poisoning 66	Suicide Firearm 140	Suicide Firearm 189	Suicide Firearm 144	Unintentional Fall 39	Unintentional Unspecified 225	Undetermined Poisoning 835
4	Homicide Other Spec., classifiable 4	Unintentional Suffocation 10	Unintentional Fall 3	Undetermined Suffocation 4	Undetermined Poisoning 21	Suicide Suffocation 41	Suicide Suffocation 81	Suicide Poisoning 99	Suicide Poisoning 78	Undetermined Poisoning 34	Suicide Firearm 134	Unintentional Fall 464
5	Unintentional Drowning 4	Homicide Unspecified 7	Unintentional Suffocation 3	Unintentional Drowning 3	Suicide Poisoning 16	Suicide Poisoning 35	Suicide Poisoning 69	Unintentional Poisoning 75	Unintentional Poisoning 57	Suicide Poisoning 29	Unintentional Suffocation 96	Suicide Poisoning 351
6	Homicide Suffocation 3	Homicide Other Spec., classifiable 6	Unintentional Other Spec., NEC[N] 2	Unintentional Fall 3	Unintentional Fall 15	Homicide Firearm 30	Unintentional Poisoning 49	Suicide Suffocation 71	Suicide Suffocation 39	Unintentional Poisoning 18	Adverse Effects 75	Suicide Suffocation 307
7	Adverse Effects 2	Five Tied 3	Unintentional Pedal cyclist, Other 2	Unintentional Firearm 3	Homicide Firearm 14	Unintentional Poisoning 23	Homicide Firearm 42	Homicide Firearm 31	Unintentional Fall 27	Adverse Effects 16	Suicide Poisoning 25	Unintentional Poisoning 251
8	Unintentional Pedestrian, Other 2	Five Tied 3	Unintentional Struck by or Against 2	Unintentional Other Land Transport 3	Unintentional Drowning 13	Unintentional Drowning 20	Unintentional Other Transport 21	Unintentional Other Transport 23	Unintentional Other Transport 21	Unintentional Other Transport 14	Unintentional Other Spec., NEC[N] 24	Unintentional Unspecified 251
9	Six Tied 1	Five Tied 3	Nine Tied 1	Four Tied 2	Unintentional Other Land Transport 12	Unintentional Other Land Transport 14	Unintentional Natural/ Environment 14	Unintentional Fall 18	Homicide Firearm 17	Unintentional Suffocation 14	Unintentional Poisoning 17	Unintentional Suffocation 190
10	Six Tied 1	Five Tied 3	Nine Tied 1	Four Tied 2	Unintentional Poisoning 8	Unintentional Fall 11	Unintentional Other Land Transport 14	Unintentional Drowning 15	Unintentional Other Land Transport 14	Unintentional Unspecified 9	Unintentional Natural/ Environment 16	Homicide Firearm 150

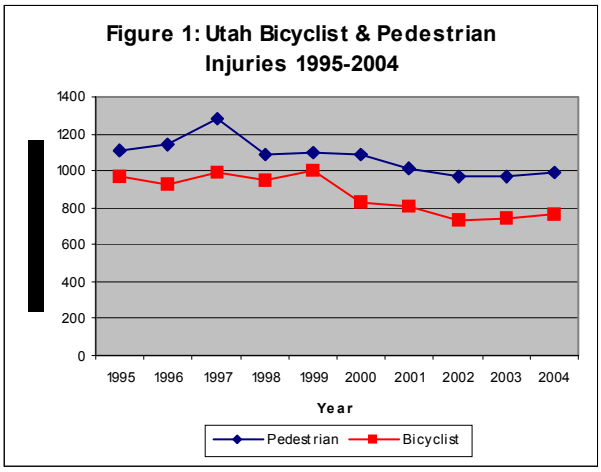
[N] Not elsewhere classifiable.

Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data Source: National Center for Health Statistics, National Vital Statistics System

Bicycle and Pedestrian Safety

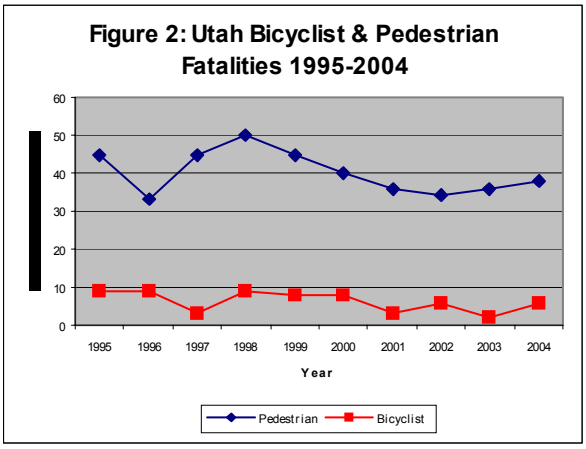
Background Information and Current Data

Walking and bicycling are excellent ways of transportation and exercise. Everyone should be able to safely walk or bicycle to school, to work, to the bus stop, or simply to explore a neighborhood. Unfortunately, walking and bicycling aren't always safe. In Utah, over the last 10 years (1995-2004) there were 19,457 reported pedestrians and bicyclists hit by motor vehicles and 465 pedestrian and bicyclist fatalities.[1] Figures 1 and 2 show the number of injuries and fatalities by year. In Utah, 1% of federal transportation funds are spent on pedestrian and bicycle projects, even though they comprise more than 10% of all traffic deaths and more than 9% of all trips made.[2,3]



Strategies Used to Prevent Bicycle and Pedestrian Injuries

Making conditions safer for pedestrians and bicyclists involves a multi-faceted approach. The three primary strategies used to enhance pedestrian and bicycle safety are often referred to as the "Three E's" – Engineering, Enforcement, and Education. All three strategies must be implemented together to have the greatest overall effect in enhancing bicycle and pedestrian safety and to prevent the greatest number of injuries and fatalities.



Engineering Strategies: Communities and streets have been largely designed to facilitate high-speed automobile traffic, treating pedestrian and bicycle safety as an afterthought. This type of design puts pedestrians and bicyclists at risk. When the built environment gives low priority to pedestrians and bicyclists, it becomes difficult for automobiles, pedestrians and bicyclists to safely share the road. However, roads that are designed to accommodate the needs of all users are safer. Engineering strategies are often classified into three broad categories: separation of pedestrians/bicyclists and automobiles (for example, sidewalks, curb extensions, tree lined streets, pedestrian only traffic signal phases, and bike lanes), measures that increase visibility and awareness of pedestrians and bicyclists (roadway lighting and diagonal on street parking), and reductions in vehicle speeds (narrower lanes, roundabouts and speed humps).[4]

Enforcement Strategies: Many laws set forth to protect pedestrians and bicyclists are ignored or not known and regularly not enforced. Traffic laws set the framework for using the roads safely, but are only effective in protecting road users when obeyed. Most motor vehicle crashes involving a pedestrian or a bicyclist can be prevented if the motorist, the pedestrian or the bicyclist, obey the law. Stricter, more reliable, and consistent enforcement can limit violations and encourage safer behaviors.

Proven strategies do exist in reducing traffic violations relating to bicycle and pedestrian safety, such strategies include: Selective Enforcement - which involves targeting violators by locations, time of day, or by type of violation committed; enforcing speed limits, especially around schools, parks, and neighborhoods, and; short-term enhanced enforcement campaigns.

Education Strategies: Knowledge is power and can be gained through education, whether taught or learned through experience. Education has the ability to influence attitude and change behavior. Road users, whether in an automobile, riding a bicycle, or walking need to know and understand traffic laws. If traffic laws and safety practices are not known or understood they cannot be followed. Therefore, it is essential that all road users, regardless of age, be taught traffic laws and safety rules.

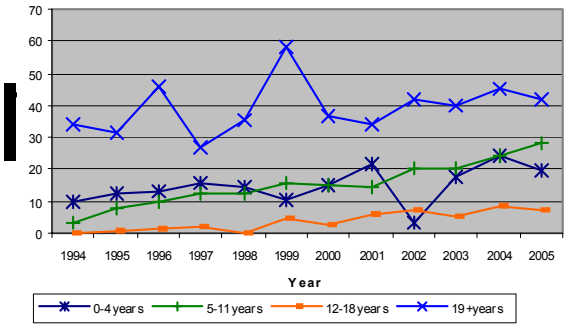
Costs of Bicycle and Pedestrian Injuries

In 2003, hospital and emergency department charges for bicyclist and pedestrian injuries sustained in crashes with automobiles totaled $20 million in Utah.[5] In addition to direct medical costs there are other costs that add significantly to the overall costs associated with bicycle and pedestrian injuries, such as: rehabilitation, lost work/wages, lost productivity, etc.

The most serious and costly injuries for bicyclists are head injuries.[6] Studies have shown that a bicycle helmet can reduce the risk of head or brain injury by 85-88%.[7]

Despite that fact bicycle helmet use is low. The good news is that bicycle helmet use is on the rise. In the U.S. in 1994, 97% of bicyclists killed were not wearing helmets and in 2004 the number of U.S. bicyclists killed not wearing helmets had dropped to 83%.[6] In Utah, helmet use rates slowly increased over the past 12 years from 5% in 1994 to 27% in 2005.[1] But there is still much room for improvement. Passing helmet legislation would increase helmet use for children and adolescents by an additional 18%.[8]

Figure 3: Percentage of Bicycle Helmet Use By Age, In Utah 94-05



Bicycle and Pedestrian Safety Action Steps

The following action items describe bicycle and pedestrian activities currently underway in the state of Utah. Listed within parentheses are federal, state, and local agencies that are in some manner addressing the specific action item.

Objectives:

1. **Reduce pedestrian deaths on public roads caused by motor vehicles to 1 per 100,000 population by 2010.**
2. **Reduce nonfatal pedestrian injuries on public roads caused by motor vehicles to 19 per 100,000 population by 2010.**
3. **Reduce nonfatal bicyclist injuries on public roads caused by motor vehicles to 19 per 100,000 population by 2010.**
4. **Increase bicycle helmet use among bicyclists to 50% by 2010.**
5. **Implement a state law requiring bicycle helmets for bicycle riders under age 15 years by 2010.**

Action Steps:

1. **Promote pedestrian and bicycle safety**
    a. Educate pedestrians and bicyclists on safety

    b. Educate drivers to avoid collisions with bicyclists and pedestrians

    c. Advocate local, regional, and state government, including Safe Communities, to support efforts that promote bicyclist and pedestrian safety

    d. Educate local law enforcement on the need for enforcement of traffic laws that help to ensure safety of bicyclists and pedestrians

2. **Increase helmet use and proper fit among bicyclists**
    a. Advocate for state legislation mandating helmet use for those ages 15 and under when riding a bicycle

    b. Increase proper helmet usage for all ages when using a bicycle

3. **Reduce the overall burden of injury resulting from bicyclist and pedestrian incidents**

4. **Manage community growth and development to promote increased safety for bicyclists and pedestrians**

a. Advocate for increased use of walking and bicycling as a safe alternative mode of transportation

b. Increase mass transit for pedestrians and bicyclists

c. Design environments to be supportive of bicyclists and pedestrians

d. Design urban environments oriented for pedestrians and less so for vehicles

5. **Support and improve surveillance systems needed to collect both mortality and morbidity that include non-motor vehicle pedestrian and bicyclist incidents**

6. **Increase support networks and social activism for bicyclists and pedestrians**
   a. Increase social activism of bicyclists and pedestrians within their communities

   b. Increase participation and outreach of local bicycling organizations and their promotion of safety

7. **Future Objective**
   a. Advocate for helmet use for in-line skates, skateboards, scooters, and other modes of travel

Motor Vehicle Seatbelt Use

Background Information and Current Data

How important are seatbelts?

Motor vehicle crashes are the leading cause of injury death and the second leading cause of hospitalization from injury for all ages in Utah.[1] Seatbelts are one of the most effective safety devices for preventing serious injuries and reducing fatalities in a crash. Seatbelts reduce the chances of being killed or seriously injured in a motor vehicle crash by approximately 50%. Seatbelts prevent ejection from the vehicle, spread forces from the crash over a wide area of the body, allow the body to slow down gradually in a crash, and protect the head and spinal cord from serious injury.[2]

It is estimated seatbelts saved more than 15,400 lives in the U.S. in 2004. Yet, during this same year, 55% of passenger vehicle occupants killed in traffic crashes were unrestrained. If all passenger vehicle occupants (over 4 years old) wore seatbelts, more than 5,800 additional lives could have been saved in the U.S.[3]

Economic Costs of Not Wearing Seatbelts

Almost 85% of all medical costs for motor vehicle crash victims fall on society, and not on the individuals involved. Medical costs for unbelted crash victims are 50% higher than for those who are belted. Employer health care spending on motor vehicle crash injuries is $9 billion annually. Another $9 billion is spent on sick leave and life and disability insurance for crash victims.[4]

In 2003, seatbelts saved society an estimated $63 billion in medical care, lost productivity, and other injury-related costs. In this same year, the needless deaths and injuries from seatbelt nonuse caused an estimated $18 billion in economic costs to society.[5]

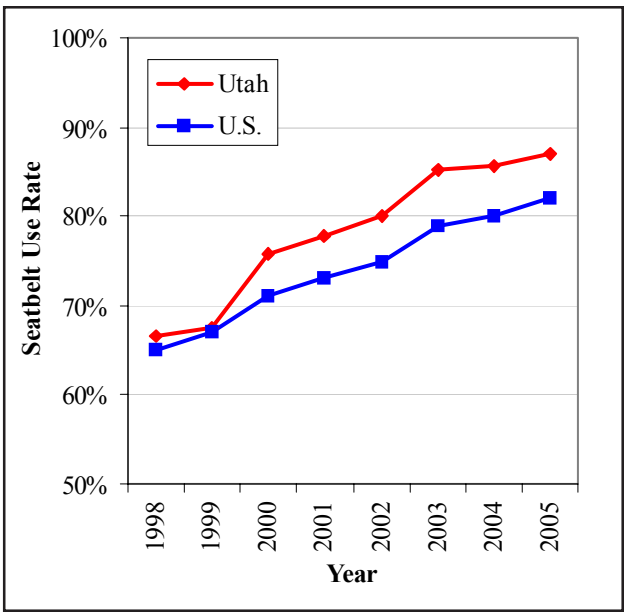
Injury and Fatality Trends Related to Seatbelt Use

On average, 320 Utah residents die, 2,100 are hospitalized, and 29,900 are treated in emergency departments because of motor vehicle crash injuries each year. The motor vehicle crash death rate has decreased in Utah from 16.0 per 100,000 population in 1999 to 13.0/100,000 in 2004. Motor vehicle crash death rates are highest in the 15-19 and 70+ age groups. Motor vehicle crash hospitalization and emergency department rates are highest in the 15-19 age group.[1]

Trends in Seatbelt Use

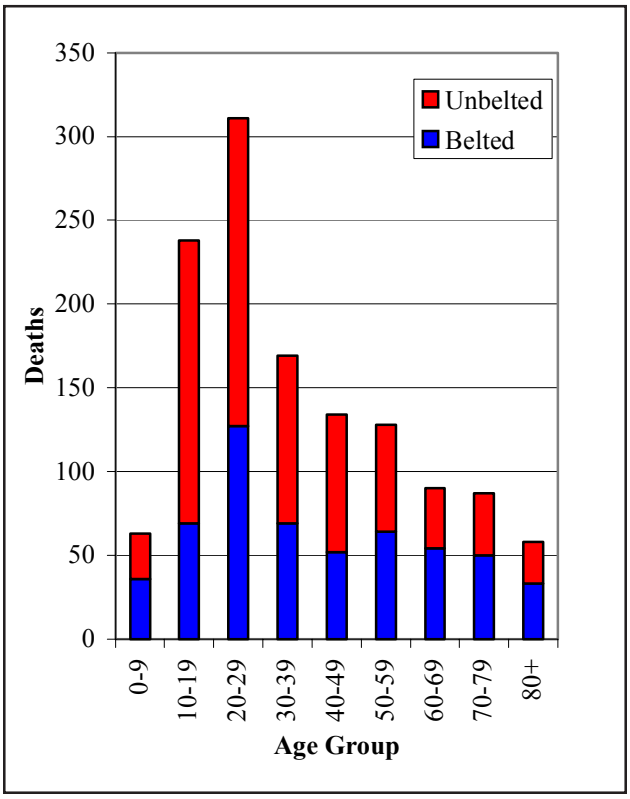
Overall seatbelt use has increased in Utah from 67% in 1998 to 87% in 2005.[6] Nationwide seatbelt use has increased from 65% to 82% during the same time period.[7]

Figure 2: Observational Seatbelt Use, Utah[6] vs. U.S.[7], 1998-2005



Ages 10-19 have the lowest seatbelt use among crash occupants in Utah.[8] As shown in Figure 2, less than 50% of Utah occupants ages 10-49 years who died were wearing a seatbelt. Lower seatbelt use is associated with males; night driving; drivers of pickup trucks; older vehicles; rural roadways; weekend driving; drinking and driving; speeding; being a passenger; secondary roads; low level of education; short journey; unlicensed drivers; and unbelted driver.[9]

Figure 2: 1999-2004 Utah Occupant Deaths, by Age and Restraint Use[8]



Seatbelt Laws

Utah is one of 28 states that enforces a secondary seatbelt law.[3] A secondary seatbelt law gives a police officer the right to ticket a person not wearing a seatbelt only if they are stopped for another traffic violation. Primary laws give the police officer the right to stop and ticket any person that is not wearing a seatbelt. Seatbelt use is higher in states that have primary seatbelt laws than in states without primary laws. It is estimated that enacting primary seatbelt laws for all states from 1995-2002 would have saved over 12,000 lives nationally and over 172 in Utah.[10]

Highly publicized primary seatbelt laws and visible increased enforcement of seatbelt laws have been shown to be the most effective in increasing seatbelt use.[2,4]

Seatbelt Action Steps

The following action items describe seatbelt activities currently underway in the state of Utah. Listed within parentheses are federal, state, and local agencies that in some manner are addressing the specific action item.

Objectives:

1. **Increase seat belt use to 92% by 2010.**
2. **Reduce deaths from motor vehicle crashes to 14 per 100,000 population by 2010.**
3. **Reduce nonfatal injuries caused by motor vehicle crashes to 933 per 100,000 population by 2010.**

Action Steps:

1. **Education and awareness**
    a. Seminars and conferences to increase seatbelt awareness

    b. Public awareness campaigns to increase targeting higher-risk populations

    c. Target employers to increase employee awareness and use of seatbelts both on and off the job

    d. Provide specific classes or courses that include use of seatbelts

    e. Provide both printed and public announcements (via radio, television, internet and other communication mediums) to educate the public about seatbelt use

2. **Legislative support**
    a. Garner support for enforcement of secondary seatbelt law

    b. Educate the state legislature and government to support evidence based initiatives that could increase seatbelt usage such as a primary seatbelt law

3. **Behavioral support**
    a. Require seatbelt use for employees when they are working

    b. Demonstrate the outcome of a crash when seatbelts aren't used

    c. Administer programs or activities that provide positive reinforcement for seatbelt use

    d. Support enforcement of laws that penalize individuals for lack of seatbelt use

4. **Law enforcement**
    a. Enforce the secondary seatbelt law

5. **Surveys and assessments**
    a. Collect seatbelt use-related data

6. **Funding**
    a. Provide funding for seatbelt use, awareness, and education

    b. Provide funding for seatbelt enforcement

7. **Future objective**
    a. Advocate for a primary seatbelt law in Utah

    b. Support better data collection and analysis of all factors related to seatbelt use

    c. Continue support of research into and evaluation of seatbelt interventions

    d. Use social marketing principles to encourage seatbelt use

    Continue building a network of resources working to support proper safety restraints

Child Restraint Safety

Background Information and Current Data

How Important are Child Restraints?

Evidence suggests that unrestrained or improperly restrained children are more likely to be injured, to suffer more severe injuries, and to die in motor vehicle crashes than children who are restrained. Unrestrained children are four times as likely to be injured as those in a child restraint system.[1]

Definition and Types of Child Restraints

Child restraint devices vary by type and method of restraint depending on the age of the child. The three main groups of children requiring a restraint are infants (<1 year old), toddlers (1-3 years old), and booster age children (4-7 years old). Restraints used include, rear-facing child seat, forward-facing child seat, booster seat. Seatbelts or Lower Anchors and Tethers for Children (LATCH) may be used to anchor restraint devices.[2] The back seat is generally the safest place in a crash. If a vehicle has a passenger air bag, it is essential for children 12 and under to ride in the back seat.[3]

Child Restraint Use

While 99% of infants and 94% of toddlers were in child safety seats, the number of restrained children ages 4-7 dropped from 83% to 73% in the U.S. in 2004. Unfortunately, 19% of restrained children ages 4-7 used appropriate booster seats, while the remaining children had graduated prematurely to safety belts.[4] In Utah in 2004, 86% of 0-1 year olds and 73% of 2 to 4 year olds were reported as being in a car seat at the time of the crash, while only 14% of 5-8 year olds were reported as being in a child safety seat.[5] Even though infant and toddler child restraint use is high, there is room for improvement among all ages, especially among booster seat-age children.

Defining Correct Usage

It is estimated that four out of five child safety seats are installed incorrectly.[6] The most common critical misuses are:

- Failing to attach the seat tightly to the vehicle
- Failing to fasten the harness tightly around the child
- Using the chest clip incorrectly
- Visible damage to the seat (e.g., cracked seat shell, torn harness strap, broken harness parts)
- Age and weight appropriateness of seat
- Incorrect seat direction
- Placement of seat in relation to air bags[7]

Lack of any restraint use in the motor vehicle is the greatest risk for children getting injured in a crash.[7]

Community Interventions

There is a significant decrease in restraint use among the 5-9 age group when compared to the 0-4 age group. This decrease in restraint use shows the critical need for public information and education about the importance of restraint use, along with the need for ongoing enforcement of existing laws.[8]

Many community efforts have been implemented to educate the public about the importance and proper use of child restraints. Studies have shown that educating parents about safety restraints when leaving the hospital with a newborn child increases likelihood of subsequent use, both short term (immediate use after leaving the hospital) and long term (observed increased use months after the hospital training).[9] Community educational

efforts should include basic child passenger safety messages stressing secure child safety seat attachments, keeping children in child safety seats until safety belts fit them properly, having parents place children in the proper child safety seat for their size, and never placing children in the front seat with a front passenger air bag.[4] Protecting children when they ride in motor vehicles is the responsibility of all community members.

Child Restraint Laws

Utah has a primary seatbelt law for drivers and passengers under age 19 years. Children age 4 years and under must ride in an approved child safety seat and those children 5-19 years must ride in an approved child safety seat or safety belt. This primary law means a person may be issued a citation and subject to a fine of not more than $45 if a law enforcement officer notices children are not properly restrained.[5] However, the law does not clearly define appropriate restraint of children over age 5. States with primary enforcement seat belt laws have an average belt use 10-15% higher than those with secondary enforcement.[10]

An upgrade in a State's safety belt law to primary enforcement will significantly raise safety belt and child safety seat use because increasing adult safety belt use has a significant impact on whether children are appropriately restrained. Studies show that when drivers wear safety belts, children are restrained significantly more often than when drivers are unbuckled.[7,10]

Child Restraint Action Steps

The following action items describe child restraint activities currently underway in the state of Utah. Listed within parentheses are federal, state, and local agencies that are in some manner addressing the specific action item:

Objectives:

1. **Increase child restraint use by motor vehicle occupants aged 4 years and under to 100% by 2010.**
2. **Reduce deaths from motor vehicle crashes to14 per 100,000 population by 2010.**
3. **Reduce nonfatal injuries caused by motor vehicle crashes to 933 per 100,000 population by 2010.**

Action Steps:

1. **Education and awareness**
    a. Seminars and conferences to increase child restraint awareness

    b. Public awareness campaigns to increase child restraint awareness, especially for targeted or higher-risk populations

    c. Provide specific classes or courses that include use of child restraints

    d. Provide printed and other mediums of public announcements and information (via radio, television, internet) to educate the public on proper child restraint use

2. **Legislative support**
    a. Seek legislative support for resources that promote proper child restraint use

3. **Behavioral support**
    a. Provide car seat programs for the community that includes restraint installation and education to increase proper placement and use of child restraints

    b. Provide to the public a visual representation of vehicle crash outcomes when child restraints aren't used

    c. Provide programs or activities that encourage use of child restraints

    d. Inspection and checkpoint services to assess proper placement of child restraints

4. **Law Enforcement**
    a. Enforce child restraint laws

5. **Surveys and assessments of child restraint use and proper placement**
    a. Support the gathering of child restraint information for data collection and assessment

6. **Provide funding**
    a. Seek and provide funding for awareness and education

7. **Future objective**
    a. Support data collection and analysis for child restraints

    b. Use social marketing principles to encourage proper use of child restraints

    c. Continue building a network of resources working to support proper child restraint use

Sexual Violence

Background Information and Current Data

Definition of Sexual Violence

Sexual violence is a sex act completed or attempted against a victim's will or when a victim is unable to consent due to age, illness, disability, or the influence of alcohol or other drugs. Sexual violence also includes intentional touching of the genitals, anus, groin, or breast against a victim's will or when a victim is unable to consent; and voyeurism, exposure to exhibitionism, or undesired exposure to pornography. [1]

Occurrence of Sexual Violence

- The National Violence Against Women Survey found that 1 in 6 women and 1 in 33 men in the United States have experienced an attempted or completed rape at some time in their lives.[5]

- Fewer than half (48%) of all rapes and sexual assaults are reported to the police.[6]

- According to the 2003 Youth Risk Behavior Surveillance System, a national survey of high school students, 7.7% of students had been forced to have sexual intercourse when they did not want to.[4]

Groups at Risk of Sexual Violence

- A recent National Crime Victimization Survey found that women were 16 times more likely than men to experience rape or sexual assault.[6]

- Females ages 12 to 24 are at the greatest risk of experiencing rape or sexual assault.[6]

- Most perpetrators know their victims. According to the 2000 National Crime Victimization Survey, 62% of rape and sexual assault victims knew the perpetrator. More than 40% of female rapes and sexual assaults were perpetrated by a person the female victim called a friend or acquaintance.[6]

Healthy People 2010 Objectives

The Healthy People 2010 objectives promote reductions in attempted and completed sexual violence. The numbers of attempted and completed instances are reported as 1,000 people per year.

Table 1 compares Healthy People 2010 objectives with incidents reported in Utah.[2] Concerted efforts by states and private organizations will be needed to meet these goals.

Table 1.

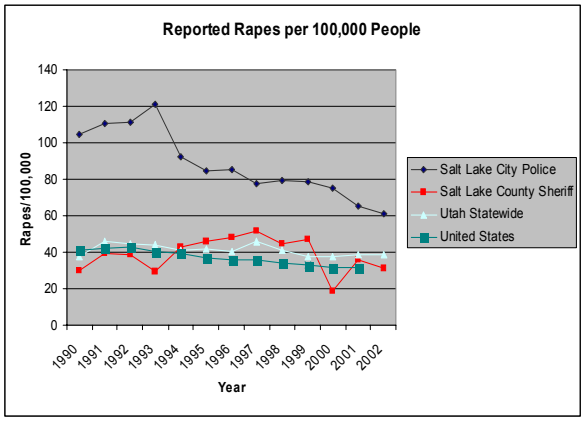
Objective Baseline Year (1998)	2001	2010	Goal
Rape or attempted rape (per 1,000 population, aged 12 years and over) National	0.8*‡	0.7*‡	0.7
Rape (per 1,000 population) Utah	0.41†	0.39†	0.7
Sexual assault other than rape (per 1,000 population, aged 12 years and over) National	0.6*	0.5*	0.4

** National figures are based on a household survey. The survey includes incidents that may or may not have been reported to police.*
† Utah figures are based on reports to police and most likely underestimate true rates of sexual violence in Utah.
‡ Reported rates per 1,000

Reported Sexual Violence Trends in Utah

Figure 1 represents yearly reported rates (reported to and substantiated by law enforcement) of rape in Utah from 1990 to 2002.[3]

Figure 1.



Dating Violence

An often-overlooked topic directly relating to sexual violence is dating violence. Utah, having a large younger population, may demonstrate a potential for a significant frequency of dating violence. The following definition and facts regarding dating violence are provided by the Centers for Disease Control and Prevention (CDC).

Occurrence of Dating Violence

Violent behavior that takes place in a context of dating or courtship is not a rare event. Estimates vary because studies and surveys use different methods and definitions of the problem.

Data from a study of 8th and 9th grade male and female students indicated that 25% had been victims of nonsexual dating violence and 8% had been victims of sexual dating violence.

Sexual Violence Prevention, Action, and Services

The following action items describe sexual violence prevention, action, and services currently underway in the state of Utah. Listed within parentheses are federal, state, and local agencies that in some manner are addressing the specific action item.

Objectives:

1. **Reduce incidences of rape in Utah to 97.0 per 100,000 women ages 15 years and older by 2010.**
2. **Reduce the annual rate of rape or attempted rape to 70 per 100,000 persons aged 12 years and older by 2010.**
3. **Reduce sexual assault other than rape to 40 per 100,000 persons aged 12 years and older by 2010.**

Action Steps:

1. **Sexual violence prevention and intervention**
    a. Implement proactive policies and interventions targeting the community in relation to sexual violence

2. **Education and training about sexual violence**
    a. Educate to prevent, recognize and intervene in relation to sexual violence issues (in a targeted community, such as schools or the community at large.

    b. Provide conferences to educate about sexual violence for those serving the community

    c. Provide training for the fellow peers, agencies and/or professions serving the community about sexual violence, i.e. residence assistants at colleges and universities, medical students, sexual assault nurse examiners, emergency medical services personnel, etc

3. **Sexual violence interventions.**
    a. Serve as a resource for prevention information, referrals, and/or treatment for sexual violence

    b. Serve as a resource for crisis information, referrals, and/or treatment for sexual violence

    c. Provide educational materials (print, internet, video, audio) relating to sexual violence

    d. Support programs that provide additional interventions (not directly related to sexual violence prevention) that impacts sexual violence such as substance abuse/alcohol treatment, Safe and Drug Free Schools, etc

    e. Support existing and develop future programs that assess and address groups with higher rates or potential risk for sexual violence

f. Provide and/or support crisis phone lines for victims

g. Provide case management for sexual violence victims

h. Provide individual and/or group counseling for the victims and/or family

i. Provide medical assessment, treatment and/or management to sexual violence victims

4. Sexual violence legislation, law, law enforcement, and government related support

a. Provide education about sexual violence to the state legislature

b. Initiate and/or support investigation, including interviewing, of possible sexual violence cases

c. Provide training to law enforcement using Peace Officer Standards of Training (POST) and sex crime investigation training

d. Support multi-disciplinary meetings and management of sexual violence cases

e. Aid with general legal representation for victims

f. Aid with legal representation for children

g. Provide reparation for victims of crime

h. Aid with prosecution of offenders

i. Support Victim Identification and Notification Everyday (VINE) service. The Utah VINE Program allows crime victims, as well as other members of the community, access to inmate information.

j. Support and enforce a Sex offender Registry

5. Sexual violence and social capitol (i.e. organizations working collaboratively to accomplish goals of mutual social benefit)

a. Collaborate and coordinate resources for sexual violence intervention and prevention

b. Create collations that improve community outreach and trust such as neighborhood and organizational coalitions that address sexual violence

c. Disseminate information to the public and those invested in sexual violence interventions

Intimate Partner Violence

Background Information and Current Data

Intimate partner violence—or IPV—is defined as actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner. Intimate partners may be heterosexual or of the same sex. Some of the common terms used to describe intimate partner violence are domestic abuse, spouse abuse, domestic violence, courtship violence, battering, marital rape, and date rape.[1]

National Estimates

- Approximately 1.5 million women and 834,700 men are raped and/or physically assaulted by an intimate partner each year.[18]
- As many as 324,000 women each year experience IPV during their pregnancy.[11]
- An estimated 5.3 million IPV victimizations occur each year among women ages 18 years and older.[11]
- IPV victims lose approximately 8 million days of work.[3]
- One-third of female homicide victims were killed by an intimate partner.[3]
- The health care costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion each year, nearly $4.1 billion of which is for direct medical and/or mental health care services.[8]

Utah Estimates

- A Utah-based study reported a one-year IPV prevalence rate of 9.7 percent of women seen in a local hospital emergency department.[4]
- This same study reported a lifetime IPV prevalence of 36% for women seen in the hospital emergency department.[4]

Healthy People 2010 Objectives

The Healthy People 2010 objectives promote reductions in physical assault by intimate partners. Physical assault percentages are based on incidents per 1,000 people per year. Table 1 compares Healthy People 2010 objectives with physical assault rates in Utah for the year 1998 and 2001.[5,6] Concerted efforts by states and private organizations will be needed to meet these goals.

Table 1. Objective	**1998**	**2001**	**2010 Goal**
Physical assault by intimate partners ages 12 and over /1,000 population (National)	4.4%†	2.6%	3.3%
Physical assault by intimate partners ages 12 and over /1,000 population (Utah)	3.3%*	2.5%*	3.3%

** Utah data are drawn from the question: "When asked if a spouse, significant other, partner, or other family member injured you with an object or weapon, or hit, slapped, pushed, or kicked you," contained in the Utah Crime Victimization Surveys for 2000 and 2002.*
† Reported rates per 1,000

Trends of IPV in Utah

The Utah Crime Victimization Survey, which captures IPV events through a telephone survey asks: "In the last year, did your spouse,

significant other, partner or other family member injure
you with an object or weapon, or hit, slap, push or kick you?" Figure 1 represents respondent's answers.

Figure 1.

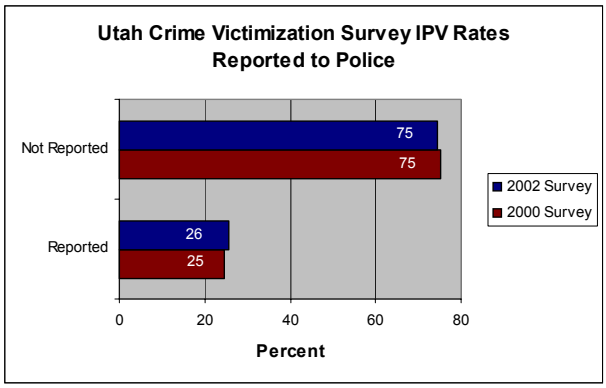
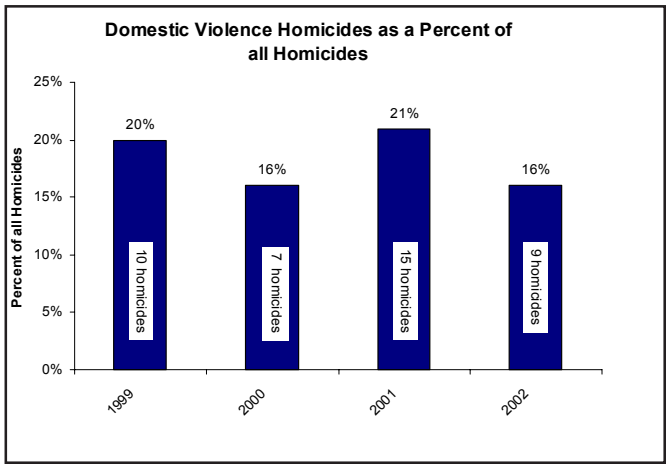


Figure 2 compares homicides as a whole to those associated with domestic violence (DV). Note, data include IPV and deaths of children.[6] A significant percentage of all homicides in Utah are a result of domestic violence.

Figure 2.



Intimate Partner Violence Prevention, Action, and Services

The following action items describe intimate partner violence (IPV) prevention, action, and services currently underway in the state of Utah. Listed within parentheses are federal, state, and local agencies that are in some manner addressing the specific action item.

Objectives:

1. **Reduce domestic violence homicides among Utah residents to 0.3 per 100,000 population by 2010.**
2. **Reduce the rate of physical assault by current or former intimate partners to 330 per 100,000 persons aged 12 years and older by 2010.**

Action Steps:

1. **IPV education and prevention**
    a. Support, implement, and evaluate violence prevention interventions

    b. Provide IPV related trainings for health care providers

    c. Provide IPV related education and training for professionals

    d. Provide IPV victim and community needed information and services to help victims and prevent re-victimization

    e. Create and disseminate to the public and IPV resource organizations an annual IPV report on the current status for the state of Utah

2. **IPV interventions**
    a. Provide crisis and information hotlines for IPV victims to access

    b. Provide emergency housing for IPV victims and their families

    c. Provide transitional housing for IPV victims and their families

    d. Provide local caseworkers for IPV victims

    e. Provide group and individual counseling or resource information to find counseling for IPV victims and/or perpetrators

    f. Provide specific assistance for children that have witnessed IPV

    g. Serve as a resource for information and services for IPV victims

    h. Serve as a resource for information and services for IPV adult and juvenile perpetrators

    i. Provide reparation for victims of crime

3. **IPV legislation, law, courts, and criminal justice**

    a. Provide victim advocacy within the judicial and criminal justice system

    b. Provide and aid in the process of obtaining protective and restraining orders, custody issues, counseling, and divorce (if needed or wanted) for IPV victims

    c. Provide education on IPV to the public and state legislature

    d. Train law enforcement personnel on responding to and addressing IPV incidents

    e. Provide victim advocacy support to accompany responding law enforcement personnel to an IPV situation

    f. Provide the V.I.N.E. (Victim Identification and Notification Everyday) service to the public. The Utah V.I.N.E. Program allows crime victims, as well as other members of the community, access to inmate information.

4. **IPV social capitol (i.e. organizations working collaboratively to accomplish goals of mutual social benefit)**
    a. Provide general community outreach, media relations, and education programs about IPV

    b. Pursue outreach programs that address minority or targeted/defined populations. Some examples could include women of color, immigrants, refugees, disabled, lesbian/gay/bisexual/transgender populations, and HIV positive individuals

    c. Collaborate and coordinate efforts with community organizations, law enforcement, judicial system, and resources associated with IPV

    d. Support existing and create future coalitions (such as local and neighborhood coalitions) that address IPV issues by various means such as providing funds, serve as a liaison for additional community resources, etc

    e. Support the "Week without Violence" program

5. **IPV surveillance and research**
    a. Review all IPV homicides to provide information relating to prevention, possible interventions and evaluation of existing services and policies

    b. Assess statewide IPV data needs (victims, perpetrators, associated family members, communities trying to address IPV, specific population/minorities)

    c. Evaluate short term and long term effects of transitional housing

6. **Caregiver abuse**
    a. Investigate reports of caregiver abuse

Suicide

Background Information and Current Data

In the United States, suicide is the eighth leading cause of death for all individuals and the third leading cause of death for young adults aged 15-24. Suicide attempts contribute to disability and suffering for hundreds of thousands of Americans each year.

In 2001, suicide was the second leading cause of death for Utahns age 10-34 and the leading cause of death among those age 35-44. While Utah statistics are similar to those across the nation, there are unique challenges for public health professionals working to prevent suicide in Utah.[1] The stigma associated with suicide is a barrier for both public health professionals and the general population, as some individuals are uncomfortable discussing the extent of the problem in Utah. Dialogue and action are beginning, but more work is necessary to build a solid foundation for addressing this difficult public health issue.

National Estimates for 2001

- Approximately 765,000 suicide attempts in the U.S. each year
- 3 female suicide attempts for each male attempt
- 4 male suicide deaths for each female death
- 5 million living Americans have attempted to kill themselves
- One suicide death every 17 minutes

Utah Estimates for 2001

- 5 male deaths for each female death by suicide
- White males ages 40-45 committed suicide more than any other group
- One in 10 suicide deaths were under age 20; 2.5% were under age 15
- More than half of victims were suspected to be under the influence of drugs or alcohol at the time of the suicide
- Nearly half were unemployed at the time of the suicide
- 18% were veterans
- Emergency medical services personnel were two times more likely to respond to the scene of an urban suicide than a suicide in a rural area.[2]

Healthy People 2010 Objectives

Healthy People 2010 objectives include reducing suicide overall, targeting suicide attempts in grades 9-12, increasing emergency department referrals to appropriate care for those attempting suicide, and increasing overall awareness and education about suicide in the school system. Note that there are limited data sources to support many objectives. Utah faces a challenge to reduce its high rates of suicide to meet the Healthy People 2010 goals (see Table 1).

Table 1.

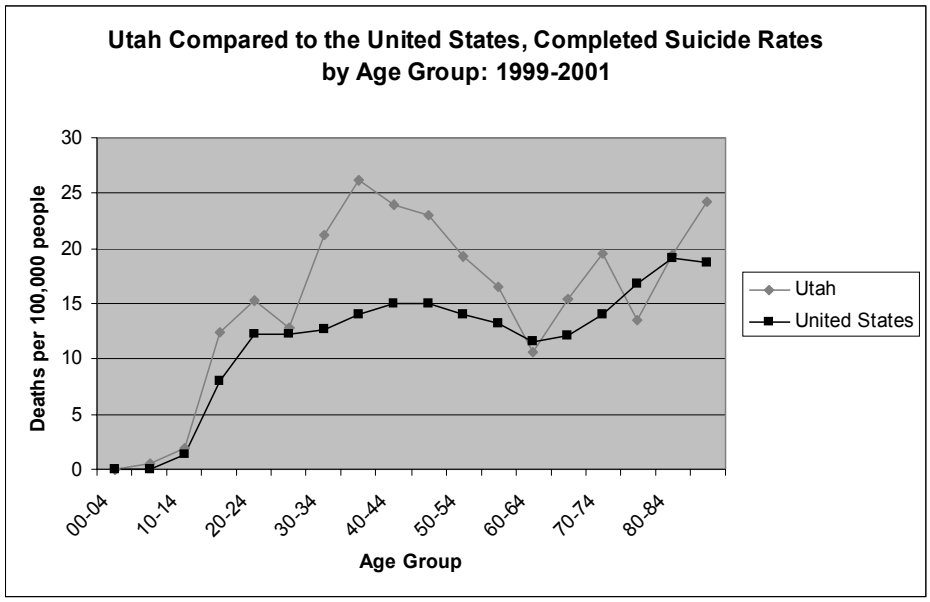
Healthy People Objective	2000	2001	2010 Goal
Suicide Completion (U.S.)	10.4*	10.7	5
Suicide Completion (Utah)	14.7	15.4	5
Suicide Attempts Grades 9-12 (U.S.)	NA	2.6%	1%
Suicide Attempts Grades 9-12 (Utah)	3.3%	3.9%	NA

**Reported rates per 100,000*

Comparing Utah and U.S. Suicide Rates

Figure 1 compares Utah suicide rates to the rest of the nation for years 1981-2001.[1] (See next page.)

Figure 1.



and the U.S.[3] Utah rates are higher
between ages

Suicide Prevention, Action, and Services

The following action items describe suicide prevention, action, and services currently underway in the state of Utah. Listed within parentheses are federal, state, and local agencies that are in some manner addressing the specific action item:

Objectives:

1. **Reduce the suicide rate to 5 suicides per 100,000 population by 2010.**
2. **Reduce suicides among Utah residents 15-19 years of age to 13.4 per 100,000 population by 2010.**
3. **Reduce the rate of suicide attempts by adolescents in grades 9 through 12 to a 12-month average of 1 percent by 2010.**

Action Steps:

1. **Suicide advocacy**
    a. Implement policy related to evidence-based strategies in order to reduce the stigma associated with suicide and associated mental health treatment in the Utah community

    b. Support "Week without Violence" campaign

2. **Suicide education**
    a. Educate the general population in Utah regarding risk factors and protective factors for suicide

    b. Educate the school population (teachers, parents, students) about risk and protective factors for suicide

    c. Provide educational materials (print, web, video, audio) relating to suicide and/or mental health

    d. Provide state and local conferences to educate the general public and health professionals about risk and protective factors for suicide, especially for those individuals who serve members of their community

3. **Suicide interventions**
    a. Serve as a referral resource for appropriate identification of risk factors for suicide including mental illness, as well as appropriate referrals for mental health treatment

    b. Support existing and develop future evidence-based interventions in order to identify potential risks for suicide among specific populations with higher suicide rates

    c. Support treatment interventions that adhere to evidence-based practice guidelines in related areas such as substance abuse interventions

d. Screen youth in the Juvenile Court System to identify those at risk for suicide and refer to appropriate mental health treatment

4. **Suicide legislation, law enforcement, and government related support.**
   a. Develop and support proactive mental health policies regarding suicide

   b. Provide education and advocacy on suicide to the state legislature (lobbying)

5. **Suicide and social capitol (i.e. organizations working collaboratively to accomplish goals of mutual social benefits)**
   a. Coordinate prevention and research resources in order to foster community involvement regarding evidence-based practice to prevent suicide and decrease stigma associated with suicide and mental health treatment

   b. Disseminate information to the public and those interested in planning, implementing, and evaluating evidence-based suicide prevention strategies

6. **Suicide Surveillance**
   a. Review all child fatalities under age 21 ruled suicide by the Office of the Medical Examiner

   b. Support and use the National Violent Injury Surveillance System (NVISS) to track suicide patterns in the State of Utah

   c. Develop, evaluate and/or implement questionnaire to screen youth for distress and dysfunction associated with mental illness

7. **Suicide research and reporting**
   a. Develop, support, and/or disseminate lessons learned from the Utah Youth Suicide Study. Youth Suicide Study includes six phases: 1) Government agency record epidemiology, 2) Parent interview, 3) Community contact interviews, 4) Genetic studies, 5) Mental health assessment of youth in the Third District Juvenile Court, and 6) Rapid access to mental health treatment for youth at highest risk- male youth in the Third District Juvenile Court.

8. **Future objectives**
   a. Improve and expand surveillance systems to gather more complete information about specialty populations at risk for suicide such as minority populations, elderly, adults, and migrants

   b. Develop evidence-based strategies to decrease the stigma associated with suicide, mental illness, and mental health treatment

   c. Concentrate future research on suicide attempters in addition to completers

   d. Develop, implement, and evaluate guidelines for government agency personnel who work with populations at risk for suicide to facilitate the appropriate identification of risk factors, and referral for mental health treatment.

Child Maltreatment

Background Information and Current Data

What is Child Maltreatment?

The Centers for Disease Control and Prevention (CDC) defines child maltreatment (child abuse and neglect) as "at a minimum, any recent act or failure to act on the part of a parent or caregiver that results in death, serious physical or emotional harm, or sexual abuse or exploitation; or an act or failure to act that presents an imminent risk of serious harm."[1]

The Child Abuse Prevention and Treatment Act identifies four major types of maltreatment: physical abuse, child neglect, sexual abuse, and emotional abuse.

Occurrence of Child Maltreatment

In 2000, an estimated 879,000 children in the U.S. experienced or were at risk for child abuse and/or neglect. An estimated 1,200 children died from such maltreatment.[2] That year, 63% of victims suffered neglect, 19% were physically abused, 10% were sexually abused and 8% were emotionally or psychologically maltreated.[2]

Consequences of Child Maltreatment

- Both males and females who have experienced maltreatment are at increased risk for experiencing intimate partner violence as adults.[3]
- Shaken-baby syndrome. An estimated 20 to 25% of infant victims with shaken-baby syndrome die from their injuries. Nonfatal consequences of shaken-baby syndrome include blindness, cerebral palsy, and cognitive impairment.[4]
- Children who have experienced abuse and neglect are at increased risk for suffering adverse health effects and behaviors as adults, including smoking, alcoholism, drug abuse, depression and suicide.[5]

Groups at Risk for Maltreatment

Infants are at greatest risk for dying from homicide during the first week of infancy, with the risk being highest on the first day of life.[6] Children younger than 12 months account for 44% of child maltreatment fatalities.[2]

Male and female children experience similar rates for all types of maltreatment, except child sexual abuse, which is four times higher among females than males.[2]

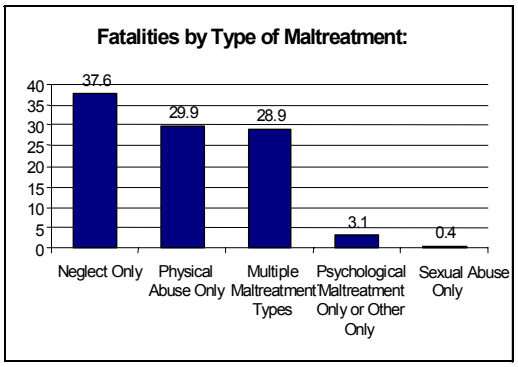
Information on Maltreatment in Utah and the Nation

National and State Victim Characteristics

Statistics gathered by the National Child Abuse and Neglect Data System show that child protective service agencies received 2.6 million reports of possible maltreatment in 2002. Of these, 896,000 were substantiated and most involved neglect. The U.S. Department of Health and Human Services reports the rate of child neglect and abuse in 2002 was 12.3 out of every 1,000 children, about 20 percent lower than the rate in 1993.[7]

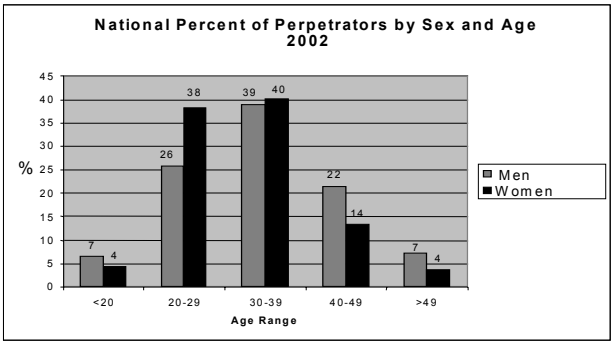
Figure 1 illustrates the type of abuse linked to the child maltreatment deaths reported nationally in 2002. Neglect was most often associated with child death.[7]

Figure 1: Distribution of Fatalities by Maltreatment Type, 2002*



Perpetrator Characteristics

Figure 2: Identifies perpetrators by age and sex nationally. Of note are increases in the percentage of female perpetrators during their young adult years and increases among men later in life.[7]



Placement of Maltreatment Victims

When suspected abuse is reported, authorities may opt to remove a victim from the home while the case is being investigated. Figure 3 illustrates the relative percent of children (victims and non-victims such as siblings and other children in the household) removed from the home during 2002.[7]

Figure 3

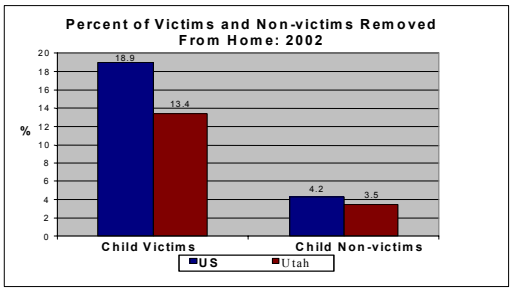
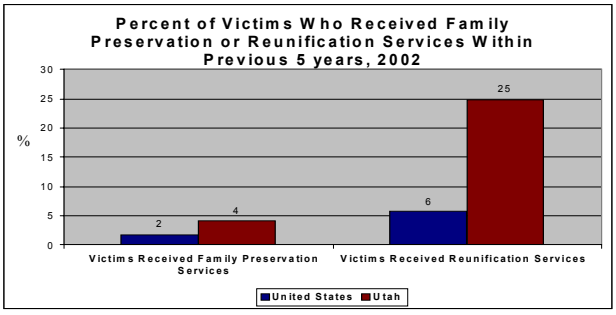


Figure 4 shows Utah and U.S. victims receiving family reunification and preservation services.[7]

Figure 4



Child Maltreatment Prevention, Action, and Services

The following action items describe child maltreatment prevention, action, and services currently underway in the state of Utah. Listed within parentheses are federal, state, and local agencies that are in some manner addressing the specific action item.

Objectives:

1. Reduce maltreatment of children to 1,030 child victims per 100,000 children under age 18 years by 2010.
2. Reduce maltreatment fatalities of children to 1.4 per 100,000 children under age 18 years by 2010.

Action Steps:

1. Education and training regarding child maltreatment

a. Educate to recognize and intervene when child maltreatment is suspected (from a targeted community, such as a school or the community at large)

b. Provide conferences to educate those servicing the community about child maltreatment

c. Provide training for the health agencies and/or professionals serving the community about child maltreatment (i.e. medical students, medical services personnel, etc.)

2. Child maltreatment prevention and interventions.

a. Serve as a resource for prevention information, referrals, and/or treatment for child maltreatment

b. Provide educational materials (print, internet, video, audio) relating to child maltreatment

c. Support programs that provide additional interventions (not directly related to child maltreatment prevention) that impacts child maltreatment such as substance abuse and alcohol treatment, mental health treatment, Safe and Drug Free Schools, education programs for children with developmental delays, funding for homes with limited financial resources, alternative schools, etc

d. Support existing and develop future programs that assess and address potential at-risk populations with higher child maltreatment incidence or potential for child maltreatment

e. Provide emergency shelter for domestic violence and child maltreatment cases

f. *Provide case management for child maltreatment victims*

g. *Provide specific programs for family support relating to child maltreatment*

h. *Provide counseling for victims and/or family*

i. *Provide medical treatment and/or management to child maltreatment victims*

j. *Support a medical assessment team (for outpatient, inpatient, and case consultation)*

k. *Support Children's Justice Centers statewide*

3. **Child maltreatment legislation, law, law enforcement, and government related support**
   a. *Develop and support proactive policies regarding child maltreatment*

   b. *Provide education about child maltreatment to the state legislature*

   c. *Initiate and/or support investigation of possible child maltreatment cases*

   d. *Assist with court or court orders to protect victims and potential victims*

   e. *Aid in criminal prosecution*

4. **Child maltreatment and social capitol (i.e. organizations working collaboratively to accomplish goals of mutual social benefit)**
   a. *Collaborate and coordinate efforts and resources for child maltreatment prevention*

   b. *Create collations that improve community outreach and trust such as neighborhood and organizational coalitions that address child maltreatment*

   c. *Disseminate information to the public and those invested in child maltreatment interventions*

5. **Child maltreatment surveillance**
   a. *Child Fatality Review Committee*

6. **Child maltreatment research, grant management/outreach and reporting**
   a. Support future research relating to child maltreatment

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